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The Importance of the Patient-doctor Relationship in Forensic Psychiatry: a Pilot study on the Effects of the Implementation of the Scott-Miller Method

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Background

All psychiatric patients, especially forensic psychiatric patients, have many negative experiences which undermine their faith into change. If we want to stimulate patients to reorganize their way of life, to help them to quit delinquent behavior, we have to be innovative.

For the psychiatric patient the therapeutic contact can be a new opportunity to investigate new possibilities of behavior. We wondered if the method promoted by Scott Miller could help to augment therapeutic effectiveness in our practice.

Methods

During a period of five months all patients received a form at the beginning of the session with four questions concerning their well-being, and another form with four questions at the end of the session concerning their evaluation of the session.

We were looking for methods to measure the impact of this intervention (percentage of annulations, therapeutic improvement). However, it was not possible to collect reliable data. We therefore chose to present only four vignettes and to give some personal evaluation.

Research and Results

Patient A,

A man aged 39. He tells everyone that he is the most classic example of ADHD. He has a history of multiple incidents of violence and substantial drug abuse. He is divorced; he is a father of two daughters with whom he has a strong emotional contact. He is co-parenting, with his ex-wife, on the care of the daughters.

When I (HdB) met him he was promised atomoxetine (Strattera) by his former psychiatrist; however the medicine could not be restituted by his insurance company. It made him upset. After a few months atomoxetine was available but it did not help him.

The police found out that he grew marijuana in his cellar (5 plants) and he was brought to court. I declared that in my opinion cannabis seemed to be more or less the only drug to temper his mood when in stress due to ADHD. The judge cleared him from the charge and a local newspaper made an article on his case: cannabis as medication!

I continued seeing him about twice a month and reviewing situations in which his aggression was tempted. He stopped using cannabis for a while but afterwards resumed his use in a smaller dose. He lowered his intake of sertraline and incidentally used bromazepam. He handled conflicts with organizations, was involved in his return to work, and in managing his financial situation in a balanced way .

Patient A had a lot of different situations to talk about concerning his anger management. He also developed anger towards me at some point. During the evaluation he discussed if the method I tried to propose would fit in his situation. The clear difference between the first part

of the session in which the doctor seemed to be the expert and second part in which the patient could evaluate his agreement was helpful for him

Patient B

A man aged 30, divorced and father of a 6 years old son. He has a complicated relationship with his ex-wife who accuses him of being violent. He has the idea that she does not care enough about their child. His mother is partly playing a role as mediator between the two. He has a history of violence since he was a child and has had some incidents of verbal aggression at his work. He used quetiapine (anti-psychotic) and incidentally alprazolam (anxiolyticum). During the course of the session his attention shifted from the fight with his ex-wife to investigating what his own preferences were, both in contact with his son as on other areas. At work he was promoted and he got involved in a new relationship.

I saw him on a weekly base, later twice a month in order to discuss incidents in which violence could occur. We planned a session with his mother and he trained how to talk to his ex-wife about their differences in opinion on caring for the boy.

Patient B felt specially helped by the explicit attention that was given to his own opinion at the end of the session because he could reflect on his own way how to deal with the situation against that what he was told to do by others.

Patient C

is a man aged 62. He has no history of earlier violence. Three years ago he abused his wife by inserting a bottle of beer into her vagina while being manic and drunk. He was not diagnosed as bipolar before, although he had been sometimes in contact with psychiatrists because of odd behavior.

We started his treatment after a period of seclusion. He had started with lithium and shortly after our treatment the couple got together again. They both monitored the mood of the patient and had conversations about this together and with me. They got my mobile phone number so that they could call me (apart from the police) if a new dangerous situation would occur (for example: starting to drink again, beginning of a manic episode). We discussed after about a year to refer him to a psychiatric center nearby, specialized in bipolar problems, but not so much in forensic problems.

At the evaluation session he constantly told that he felt misplaced in the forensic scene and stressed his wish to be transferred to the general mental health authorities.

All three patients (see the comments in *italics*) especially enjoyed the extra time of the session for evaluation. The questions at the end of the session (where the doctor is suddenly the object about whom an impression is asked) were new: the explicit attention for their comment. It was especially helpful if this time was used to look at topics of which the patient felt that they had been omitted.

Discussion

Scott Miller has summarized his views in an article with the provocative title “Supershrinks, what is the secret of their success?” (1) The bottom line of his views is that the relationship between the patient and the doctor is an essential factor in achieving the ultimate goal: treatment of the patient.

In psychiatry we surely have biological possibilities to cure the patient. However whether the patient uses the subscribed medication is mainly influenced by the compliance: in psychotherapeutic treatment clearly the compliance of the patient is even more important. Where in forensic psychiatry there is always a certain amount of coercion you could expect

that the effectiveness of formally giving attention to patient feed back could even be bigger than in general mental health settings (2), (3).

This pilot study gives the impression that taking a well defined amount of time for patient evaluation, the effectiveness of the psychiatric relationship augments in forensic psychiatry.

Literature

Note 1

Miller, Scott D., Duncan, L, Hubble, M. Supershrinks, What is the Secret of their Success? November 2007, www.psychotherapynetworker.org

Note 2

S.Cory Harmon, Michael J. Lambert, David M. Smart, Eric Hawkins, Stevan L. Nielsen, karstin Slade, Wolfgang Lutz
Enhancing outcome for potential treatment failures : Therapist-client feed back and clinical support tools Psychotherapy research, july 2007; 17(4): 379-92

Note 3

Miller, Scott D., Barry Duncan, George Brown. Using formal client feedback to improve retention and outcome. Journal of brief therapy 5 (2006): 5-22